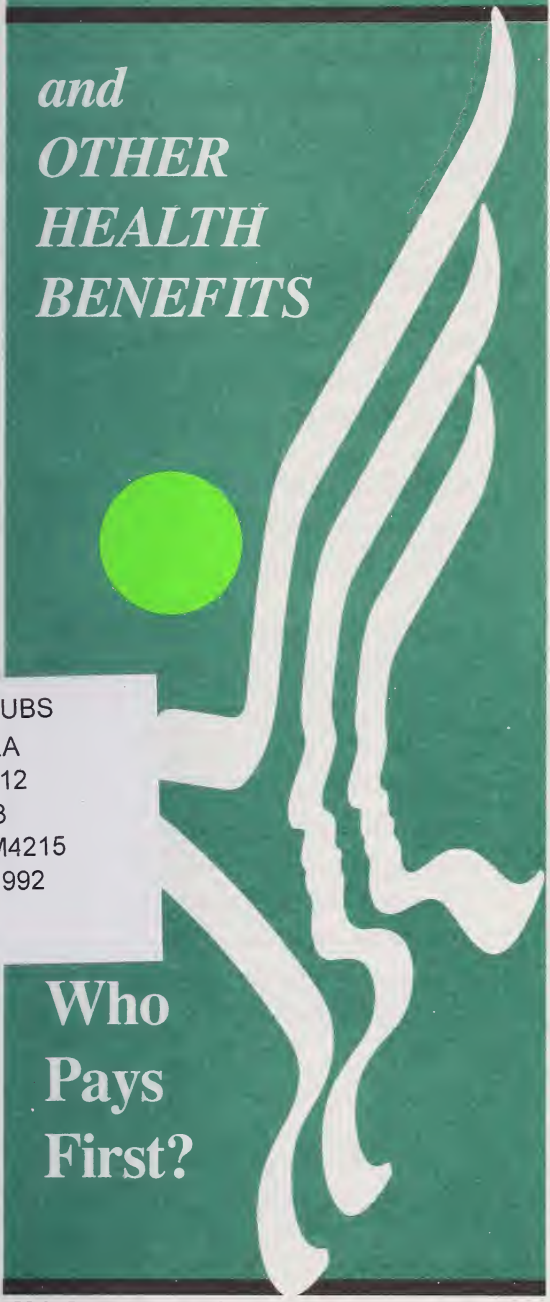
Medicare

and OTHER HEALTH BENEFITS



Who Pays First?

U.S. Department of Health and Human Services
Health Care Financing Administration

CHAPTER 1

Medicare and Employer Health Plans

If you can get Medicare and you are offered coverage under an employer health plan, you have the option to accept or reject the employer plan. The information in this booklet will help you understand who pays first on your health insurance claims.

If you accept the employer plan, it will be your primary payer. If you do not accept the employer plan, Medicare will be your primary payer and the employer cannot offer you coverage to supplement Medicare (Medigap insurance).

If you accept employer health insurance, be sure to tell your doctor and other health professionals so your bills can be sent to the employer plan first and delays can be avoided.

Medicare is the secondary payer for the following three groups of people if they have accepted an employer health plan.

People Who Are Age 65 or Over

Medicare is the secondary payer if you are covered under an employer health plan and:

- You are age 65 or over and work for an employer that has at least 20 employees, *or*

- You are age 65 or over and have a spouse of any age who works for an employer that has at least 20 employees.

Medicare is also the secondary payer if you or your spouse are self-employed and covered by an employer plan through association with a firm that has 20 or more employees.

A rule that protects you:
Employer plans must not discriminate against aged workers and spouses in the employee health benefits they offer. That is, employer plans must offer you the same health benefits under the same conditions offered to younger workers and spouses.

People Who Are Disabled
Medicare is the secondary payer if you accept an employer health plan and:

- You are under age 65 and have Medicare based on disability, *and*

- You are considered an "active individual" whose employer has 100 or more employees.

You are an "active individual" if you are disabled and can be covered by an employer health plan because you are an employee, employer, self-employed person, a business associate of an employer, or a family member of any of these people.

You are considered an employee if you are working in spite of your disability (for

example, if you are working in a trial work period). You may also be considered an employee if you are not actively working now but your employer treats you as an employee.

A rule that protects you:
If you are disabled, employer health plans cannot deny you coverage, reduce your coverage, or charge you a higher premium because you have Medicare.

People With Permanent Kidney Failure
Medicare is the secondary payer (regardless of whether you are employed full or part time or are retired) if:

- You can get Medicare solely on the basis of permanent kidney failure, *and*

- You are covered under an employer group health plan through your own employment or through the employment of your parent or spouse.

Medicare is the secondary payer for a certain period (generally 18 months). The period begins when you are eligible for Medicare Part A, whether or not you are enrolled and have a Medicare card. At the end of the period, Medicare becomes the primary payer. Please refer to *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* for information on enrolling in Medicare. To get a free copy, write to the Consumer Information Center, Pueblo, CO 81009.

A rule that protects you:
Employer health plans cannot deny you coverage, reduce your coverage, or charge you a higher premium because you have permanent kidney failure and have Medicare. That is, employer plans must offer you the same health benefits under the same conditions offered to others.

Where to Get Help

If your employer plan denies you coverage, offers you different coverage, charges you a higher premium, or pays benefits that are secondary to Medicare, notify the insurance carrier that handles your Medicare claims. Medicare carriers, their addresses and toll-free numbers are listed in the *Medicare Handbook*. You can get a free copy of the latest *Medicare Handbook* from Social Security.

CHAPTER 2

Your Employer Health Plan Choices

Must You Accept the Employer Plan?

You may accept or reject the plan offered by the employer. If you accept the employer plan, it will be your primary payer. This means the employer plan pays first on your health insurance claims. If you reject the employer plan, Medicare is your primary payer. This means Medicare pays first on your health insurance claims.

If you reject the employer plan, the employer plan:

- **Cannot** offer to pay for any Medicare-covered services and cannot offer to buy or sponsor supplemental (Medigap) coverage.

  If you feel you need additional protection, you may buy Medicare supplement health insurance ("Medigap" insurance) yourself. A Medigap policy is a private health insurance policy that fills in some of the"gaps" in Medicare's coverage when Medicare is primary payer.

- **Can** offer health insurance protection for health care services that are not covered by Medicare (such as hearing aids, eye glasses, prescription drugs or routine dental care).

NOTE: Most Medigap insurers market only to people who are Medicare beneficiaries because they are 65 or older. If you get Medicare because of disability or because of permanent kidney failure, ask your state insurance department about the availability of Medigap coverage for people under age 65 in your state.

If You Accept the Employer Plan, You Should Also Get Medicare Part A

If you have not already done so, you should apply for Medicare hospital insurance (Part A). For most Medicare beneficiaries, there is no premium for Part A. Part A can supplement your employer plan.

Contact Social Security if you have questions about buying Part A, because late enrollment can cause delays in your coverage.

If You Accept the Employer Plan, You May Want to Enroll in Medicare Part B

There is a monthly premium for Medicare medical insurance (Part B). Therefore, whether you choose to apply for Medicare Part B will depend on how fully the employer plan covers the doctors and other health services that Part B covers. You need to consider whether the secondary benefits Part B would pay are worth the cost of the premium. (You also need to consider

the timing of Part B enrollment in relation to enrollment in a Medigap plan. See the note below about Medigap.)

If you wish to enroll in Medicare Part B while you are covered by an employer plan, you can do so during your initial enrollment period (see below), or during any general enrollment period (January 1 through March 31 of each year).

NOTE: If you apply for Medigap insurance within 6 months of enrolling in Part B for the first time after becoming age 65, you may not be rejected or charged a higher premium for a policy because of poor health. This 6-month period is called your Medigap open enrollment period. The law does not permit an insurer to sell you a Medigap policy if it duplicates Medicare or other coverage. Thus, if you have an employer health plan at the time you enroll in Part B, you may be unable to purchase a Medigap policy during the open enrollment period. Therefore, if you want to take advantage of the Medigap open enrollment period, you should consider **when** it is appropriate to enroll in Part B. You will find more information about Medigap insurance in the *Guide to Health Insurance for People with Medicare*. You can get a free copy of the Guide by writing to the Consumer Information Center, Pueblo, CO 81009.

Can You Delay Applying for Medicare Part B?

Yes, but do not delay enrolling in Part B unless you are covered by an employer health plan. (You should enroll in Medicare Part A whether you have employer health plan coverage or not. For most people, there is no premium for Part A.)

If you are **not** covered by an employer health plan you should enroll in Part B during your initial enrollment period. The initial enrollment period is the seven-month period beginning three months before you were first able to get Medicare. If you enroll after your initial enrollment period is over you must wait for a general enrollment period, have your coverage begin with the following July, and you may have to pay higher monthly premiums than you would have paid if you hadn't delayed enrollment.

If you are covered by an employer health plan, you may be able to delay enrollment in Medicare Part B (or enrollment in Medicare Part A for which you must pay a premium) without paying higher premiums and without waiting for a general enrollment period to enroll. Delayed enrollment without penalty or wait is available if you have been covered by an employer health plan (not a plan for retirees) since you were first able to get Medicare.

If You Delayed Enrollment

If you delayed enrollment in Medicare Part B when you were first eligible for Medicare because you were covered under an employer plan, what can you do when the coverage ends?

In general, if you are age 65 or over, you can enroll in Medicare Part B during the 7-month period beginning with whichever month comes first:

- The month you or your spouse are no longer working, *or*
- The month you are no longer covered under the employer plan.

This enrollment period is available even if the employer plan is not your primary payer.

If you have Medicare Part A based on disability and you meet certain other requirements, you can enroll in Medicare Part B during the 7-month period beginning with whichever month comes first, the month:

- Employment status ends,
- The employer plan coverage ends, *or*
- The employer plan is no longer the primary payer of benefits.

NOTE: If you expect your employment or your coverage under an employer plan to end shortly after you first can get Medicare Part A, you should contact Social Security right away to discuss the best time to enroll in Part B.

What If You Are Disabled and Return To Work?

If you are under 65 and:

- You have premium-free Medicare hospital insurance (Part A) because you are disabled, *and*
- You go to work, even though you are still disabled,

your premium-free Medicare Part A will continue for at least 48 months. If you have Medicare medical insurance (Part B), it will also continue for at least 48 months if you continue to pay the monthly premiums.

If you lose your premium-free Medicare Part A after the 48-month period mentioned above, solely because you are working, you may buy Medicare Part A and Part B for as long as you remain disabled. (Medicare is always the primary payer for enrollees who must buy Part A.)

If you have questions about enrollment in Medicare, contact Social Security.

Contacts with Employers

A new law authorizes Medicare to use IRS and Social Security information to learn whether Medicare beneficiaries or their spouses are working. Medicare will use this information to find situations where an employer health plan may be primary to Medicare. Medicare will contact employers to confirm employer health plan coverage.

Be Sure To Tell Doctors and Other Providers About Your Other Health Plan

Hospitals, doctors, and other suppliers of covered services must submit Medicare claims for you. They need to know if you are covered under another plan that is primary to Medicare before they submit any Medicare claims. If you have coverage that is primary to Medicare, you should tell doctors and other providers:

- The name and address of the plan,
- The policy number, *and*
- That the other plan should be billed first.

CHAPTER 3

Medicare and Work- Related Illness and Injury

Workers' Compensation

Workers' compensation laws cover work-related illnesses or injuries. Most employees are covered under workers' compensation plans. If you do not know whether you are covered, ask your employer. Medicare cannot pay for any items and services if payment has been made or can reasonably be expected to be made for them under a workers' compensation law or plan of the United States or a state. If you are covered by workers' compensation and you are being treated for a work-related illness or injury, workers' compensation should be billed before Medicare.

You are responsible for taking whatever action is necessary to get any payment that can reasonably be expected under workers' compensation. You have to tell your employer that you believe you have a work-related illness or have had a work-related accident. You must make sure that a workers' compensation claim has been filed by you or on your behalf by your doctor or other health provider. There is sometimes a delay between the filing of a claim for a

work-related illness or injury and the decision by the state workers' compensation agency about whether to pay the claim. If the workers' compensation plan does not pay your claim within 120 days, a Medicare claim may be filed and Medicare may make a conditional payment.

Medicare Conditional Payments

Medicare makes conditional payments so that you will not have to use your own money to pay the bills while you wait for a decision from workers' compensation. When Medicare makes a conditional payment, you will get an Explanation of Medicare Benefits saying how much and for what services Medicare paid your doctor or other provider. These conditional payments must be repaid to Medicare when workers' compensation pays your claim.

When you get a notice from workers' compensation saying that they have now paid your claim, you should contact your doctor or other provider to make sure that they return Medicare's conditional payment.

Settlements

Sometimes workers' compensation will not agree to pay your entire claim. They may not pay the entire claim if part of the expenses would have been incurred in any case because of a preexisting condition. For example, if you already had a disc problem in your back that you only made worse on the job, and you had to have surgery on your back, workers' compensation might

only be willing to pay part of your medical bills. In this case, you and workers' compensation could agree to a compromise settlement. Then Medicare would pay for all services related to the preexisting condition as long as they are covered under Medicare. Remember, if Medicare had already made a conditional payment, the money must now be repaid to Medicare.

Black Lung

CHAPTER 4

Some Medicare beneficiaries can get medical benefits under the Federal Black Lung Program for services needed for a condition related to lung diseases and other conditions caused by coal mining. Medicare will not pay for health services covered under the Federal Black Lung Program. Black Lung benefits are considered workers' compensation benefits. Your doctor or other provider should send all claims for services that relate to a diagnosis of black lung to the following address:

Federal Black Lung Program
P.O. Box 740
Lanham, MD 20706

If the Federal Black Lung Program denies a claim for benefits, your doctor or other provider can send the bill to Medicare. They should attach a copy of the denial notice from the Federal Black Lung Program to the bill.

If you get services not related to a black lung condition, your claims should be sent directly to Medicare.

For More Information

If you need to call the Federal Black Lung Program to find out whether the claim should be sent to them or to Medicare, dial 1-800-492-5737 in Maryland or 1-800-638-7072 from any other state in the United States.

CHAPTER 5

Medicare Information For Veterans

General Information

If you have or can get both Medicare and veterans benefits, you may choose to get treatment under either program. But you have to choose one program or the other each time you need care. Medicare cannot pay for the same service paid for by the Department of Veterans Affairs (VA). Nor can the VA pay for the same service paid for by Medicare.

If You Choose to Use Your Veterans Benefits

If you choose to use your veterans benefits, Medicare generally **cannot** pay for services you get.

- Medicare **cannot** pay for the services you get from VA hospitals or other VA facilities. (There is an exception to this rule. There are cases where Medicare can pay for emergency inpatient and outpatient hospital services.)

- Medicare generally **cannot** pay if the VA pays for VA-authorized services that you get in a hospital that is not part of the VA system or from a doctor who is not affiliated with the VA. You do not always have to go to a VA hospital

or to a doctor who is affiliated with the VA for the VA to pay for your care.

If You Choose to Use Your Medicare Benefits

If you choose to use your Medicare benefits, Medicare can pay for Medicare-covered services you get from hospitals and doctors not affiliated with the VA—as long as the VA will not be paying for the same services.

When Covered Services are Different, Medicare and VA Can Each Help Pay

If the VA authorizes you to get hospital services in a hospital that is not a VA hospital, but does not pay for all the services you get during your stay, Medicare can pay for Medicare-covered services for which the VA does not pay. For example, if the VA authorizes a five-day stay and you remain in the hospital for 10 days, Medicare can pay for the Medicare-covered services you got during the five days not authorized by the VA.

VA Copayments: Sometimes Medicare Can Pay or Help Pay

The VA charges copayments to some veterans with non-service connected conditions. The copayment is the veteran's share of the cost of treatment. The veterans who are charged copayments are those at or above a certain income. Sometimes, Medicare can pay part or all of this copayment amount.

- When Medicare **cannot** pay:

  Medicare cannot pay you for VA copayments for services furnished by VA hospitals and facilities, unless the services are emergency inpatient or outpatient hospital services.

- When Medicare **can** pay:

  If the VA charges you a copayment for VA-authorized care by a doctor or hospital not affiliated with VA, Medicare may be able to pay all or part of your VA copayment.

VA Fee Basis Cards: Sometimes Medicare Can Help Pay

The VA issues "fee basis ID cards" to certain veterans. You may be issued a fee basis card because:

- You have a service connected disability;

- You will need medical services for an extended period of time; *or*

- There are no VA facilities in your area that can furnish the care you need.

If you have a fee basis card, you may choose any doctor you wish to treat you for the condition specified on the card. If the doctor accepts you as a patient and bills the VA for his or her services, the doctor must accept VA's payment as payment in full. The doctor may not bill you or Medicare for any charges not paid by the VA.

If your doctor does not accept the fee basis card, you may file a claim with the VA yourself. The VA then pays the VA-approved amount, either to you or the doctor. If the VA payment is less than the Medicare-approved amount for the services, Medicare can pay benefits to supplement the VA payment. For this to happen, your doctor must bill Medicare for that portion of his or her charges not paid by the VA. Your doctor must attach a copy of the VA's explanation of benefits to the Medicare claim form. (The VA's explanation of benefits comes with the VA payment.)

NOTE: Medicare payment may be delayed in some cases. When you choose to get your services under the Medicare program and you are also eligible for VA fee basis benefits, your VA fee basis eligibility may delay processing of your Medicare claim. The delay occurs because the contractor that pays Medicare claims must contact your doctor to make sure that the VA is not being billed for the same services for which Medicare has been billed.

NOTE: If you have Medigap insurance, it may be required to pay for VA services as if they were Medicare-covered services.

Where To Get Help

If you have questions about whether the VA or Medicare should pay for your doctor services and other medical services, contact the contractor that pays your Medicare claims. If you have questions about whether the VA or Medicare should pay for hospital services or services furnished by other facilities, ask the provider of services to contact the Medicare intermediary.

CHAMPUS and Medicare

CHAPTER 6

General Information

CHAMPUS is the Civilian Health and Medical Program of the Uniformed Services. It covers civilian hospital services and services of civilian doctors, suppliers and other providers. The program is for retired members of the uniformed services, and spouses and children of active duty, retired, and deceased members.

Most of the *CHAMPUS* beneficiaries who become eligible for premium-free Medicare Part A lose their *CHAMPUS* eligibility.

People who are under 65 and lose *CHAMPUS* coverage because of eligibility for Medicare based on kidney disease, may later lose their Medicare coverage because their condition improves. If this happens, *CHAMPUS* coverage can usually be reinstated.

NOTE: If you are living outside the United States, check your health care coverage. Medicare generally does not pay for hospital or medical services outside the United States.

People Covered By *CHAMPUS* and Medicare

Dependents of service members on active duty can always keep both *CHAMPUS* and Medicare. Three other groups can keep both. They are:

- People who are eligible for Medicare Part B only,
- People who are covered by Medicare Part A only because they buy it, *and*
- People who are entitled to Medicare based on disability (but not permanent kidney failure). These people must enroll in Part B to keep their *CHAMPUS* eligibility.

These people will not lose their *CHAMPUS* coverage when they enroll in Medicare.

Medicare Pays First

If a person has both *CHAMPUS* and Medicare, Medicare is the first payer of health care claims (unless services are furnished by a federal provider such as a military hospital. Services furnished by federal providers generally are not covered by Medicare). If Medicare does not pay the charges in full, *CHAMPUS* may supplement the Medicare payment up to the amount *CHAMPUS* would have paid if there were no Medicare coverage.

For example, *CHAMPUS* may pay the Medicare deductible and coinsurance amounts and may pay for services not covered by Medicare.

NOTE: If you have Medigap insurance, it may be required to pay for *CHAMPUS* services as if they were Medicare-covered services.

For More Information

If you have questions about whether *CHAMPUS* or Medicare should pay for your health care services, get in touch with the contractor that pays your Medicare claims. If you have specific questions about your *CHAMPUS* coverage, contact the *CHAMPUS* health benefits advisor at a Uniformed Service Medical Facility.

CHAPTER 7

Medicare and No-fault or Liability Insurance

Medicare is the secondary payer in cases where no-fault insurance or liability insurance is available as the primary payer.

If health care professionals find that the services they gave you can be paid for by a no-fault or liability insurer, they must attempt to collect from that insurer before billing Medicare.

Although Medicare benefits are secondary to benefits paid by these insurers, Medicare may make a conditional primary payment if it receives a claim which shows that these insurers will not pay within 120 days. In those cases, Medicare may pay the claim; then, when the no-fault or liability insurer pays, Medicare recovers its conditional payments.

For More Information

- If you have questions about Medicare eligibility or need enrollment information, contact Social Security. You can call the Social Security toll-free number, 1-800-772-1213 any business day from 7 A.M. to 7 P.M.

- If you have questions about what Medicare Part B covers, call the insurance company—the carrier—that processes Medicare claims in your area. Medicare carrier addresses and telephone numbers are listed in the *Medicare Handbook*. You can get a copy of the *Handbook* from Social Security.

- If you are entitled to Medicare under the Railroad Retirement system and you have questions about coverage or need enrollment information, contact your nearest Railroad Retirement Board district office.

- If you have questions about your employer group plan coverage, consult your employer plan or your employer.

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